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Circular Letter

**TO: PUBLIC AGENCIES AND SCHOOL DISTRICTS PARTICIPATING IN THE
CalPERS HEALTH BENEFITS PROGRAM**

SUBJECT: HEALTH BENEFIT OFFICER GUIDANCE

**Section I: Implementation of Domestic Partnership Coverage
(Chapter 588, Statutes of 1999, AB 26, Migden)**

Section II: Affidavit of Eligibility for Economically Dependent Children

Section III: Public Agency Vesting Requirements

Section I. Implementation of Domestic Partnership Coverage

Legislation has passed which allows domestic partners to register with the Secretary of State (Secretary) and be eligible to enroll in a CalPERS health plan. Public Agencies may elect to make this benefit available to their employees and retirees. If an agency desires to provide this benefit, the following instructions and policies will apply.

Process

The law requires the following actions for a domestic partner to be enrolled in a CalPERS health benefits plan:

- First, the Secretary must register the domestic partnership, and provide a Declaration of Domestic Partnership to the domestic partners. Specified same-sex domestic partnerships between persons who are both at least 18 years of age, and specified opposite sex domestic partnerships when both persons are over the age of 62, are eligible to register with the Secretary.
- Second, the employer must elect to provide the CalPERS health benefit plan to the employee's or retiree's domestic partner. Public agency employers must submit a change resolution to apply the benefit (Please see page 2).

- Third, the CalPERS enrollee must provide a copy of the Declaration of Domestic Partnership and a signed Statement of Financial Liability (enclosed) to their employer. Retirees must contact the CalPERS Health Benefit Services Division.

It should be noted that the law does not establish continued benefit rights (survivor entitlement) for the domestic partner in the event of the death of the member. (Please see COBRA provisions, on page 5).

When Does Enrollment Begin?

Registration of domestic partnerships under AB 26 begins January 1, 2000.

Public agency employers extending the benefit must amend their contracts with CalPERS by passing a new resolution. New resolutions will be effective on the first day of the month following CalPERS' receipt of the resolution. Public agencies should contact the our Contract Administration Unit to obtain a copy of the resolution language. Direct your inquiries to Ms. Rosie Jimenez at (916) 326-3363, Ms. Carol Abbott at (916) 326-3596, or fax your request to: (916) 326-3935.

Public agency employees and retirees may request domestic partner enrollment after employers have notified CalPERS that they will provide the domestic partner benefit and the employee or retiree receives a Declaration of Domestic Partnership from the Secretary.

Eligibility and Enrollment Rules

CalPERS will use the same enrollment policies for domestic partnerships as are currently used for traditional marriages. The eligibility and enrollment rules are stated in the Public Employees' Medical and Hospital Care Act (PEMHCA) and regulations governing the CalPERS Health Program.

Please use the following relationship codes for domestic partner enrollment transactions:

A = Domestic Partner Male	C = Domestic Partner Child Male
B = Domestic Partner Female	D = Domestic Partner Child Female

Until full system changes are made, no special reason codes will be used for these actions.

Sample HBD-12 enrollment forms are attached for your review.

Effective Date of Domestic Partner Enrollment

Domestic partner enrollment documents submitted within 60 days of the domestic partner registration will provide health benefit coverage effective on the first day of the month following the month in which the employer received the enrollment document.

Domestic partner enrollments submitted later than 60 days after domestic partner registration are considered late enrollments. The employee/dependents must wait 90 days from the date the enrollment request was received by the employer. The effective date of coverage is the first day of the month following the 90-day waiting period. If the late enrollment is made during the Open Enrollment period, the effective date of coverage is the first of the month following the 90-day waiting period, or the Open Enrollment effective date, whichever is earliest.

Enrolling

Individuals who are enrolled in a CalPERS health plan may add domestic partners and children to their health plan but cannot change plans at this time. Health plan changes will be allowed during the normal Open Enrollment period in September of 2000.

Employers may allow individuals who were eligible to enroll in a CalPERS health plan, but who declined CalPERS coverage due to the unavailability of the domestic partner benefit, the opportunity to establish a new enrollment outside of the normal Open Enrollment period for the purpose of providing coverage to their domestic partners. (See HIPPA guidelines, on page 4)

Children of Domestic Partners

Coverage:

Children of domestic partners whom an individual wishes to enroll must meet eligibility requirements established under PEMHCA regulations regarding economically dependent children. The member must submit an Affidavit of Eligibility for Economically Dependent Children (HBD-35 Rev. 11/99 attached) asserting a parent-child relationship exists with the individual.

Termination of Coverage:

Coverage of Children of Domestic Partners will be terminated for the following reasons:

- 1) The child attains the age of 23 (extensions may be requested for children with disabilities under existing rules for these cases);
- 2) The child marries;
- 3) The domestic partnership is terminated.

Reinstatement of Coverage

If a member wants to maintain the PEMHCA coverage of a child of a former domestic partner, they may do so by submitting the child for enrollment as a miscellaneous dependent child in their own right. In establishing this status, the member must provide evidence of an ongoing financial responsibility for the child as well as a continued parent-child relationship. To continue coverage for children of the domestic partner, complete the following:

- 1) HBD-12 to delete the child(ren) of the domestic partner;
- 2) HBD-12 to add the child(ren) of the domestic partner as an economically dependent child of the enrollee;
- 3) Affidavit of Eligibility for Economically Dependent Children (HBD35) to enroll a child as an economically dependent child of the enrollee.

Retain the completed HBD-35 and submit the HBD-12 to CalPERS.

Health Insurance Portability and Accountability Act (HIPAA)

CalPERS will apply the same rules as traditional marriage (for both obtaining the benefit and for potential future loss of coverage) to domestic partnerships.

Some employees or retirees may have elected not to enroll in the CalPERS plan in the past because they could not enroll their domestic partner. If an individual who had eligibility for a CalPERS health plan wants to enroll in the plan now with their domestic partner, CalPERS will allow enrollment on a current basis in any CalPERS health plan available to the enrollee. The employer must write in the REMARKS section of the HBD-12 "Domestic Partnership HIPAA Special Enrollment".

Termination of Benefits

The enrolled individual or employer must cancel the health benefits coverage of the domestic partner when the domestic partnership terminates or when the domestic partners no longer share a common residence. Upon termination of the domestic partner's coverage, coverage for children of the domestic partner, enrolled as economically dependent children under the domestic partnership, must also be terminated.

Continuation of Benefits (COBRA Entitlement)

CalPERS will offer COBRA for the event of termination of the domestic partnership or death of the enrollee under the same conditions used for traditional marriages. The employer must notify domestic partners of their COBRA entitlement and complete an HBD-85 to continue coverage for 36 months for those domestic partners electing to continue their coverage through COBRA.

Financial Liability

The enrolled individual is responsible for maintaining accurate enrollment status in the CalPERS health program. Failure to notify the employer or CalPERS of the termination of the domestic partnership shall make the enrollee liable for any and all additional expenses incurred by the domestic partner and/or his or her dependents.

Enrollment Forms Required

The following forms are required when enrolling domestic partners in the CalPERS health program. The employer must retain the forms for audit purposes. Do not send these forms to CalPERS; send only the HBD-12. Please write in the REMARKS section of the HBD-12, Declaration of DP, Statement of Financial Liability, and Affidavit (if applicable) on file.

1. Declaration of Domestic Partnership from the Secretary of State. Applications for Domestic Partnership may be obtained from the Secretary of State who is directed to distribute them to all county clerks. (Family Code Section 298).
2. Statement of Financial Liability for Domestic Partner. The attached statement shall be used, and is required by law to be submitted. (Government Code Section 22872(b))
3. Affidavit of Eligibility for Economically-Dependent Children (if applicable). This form replaces previous editions of the CalPERS affidavit, and must be used for children of domestic partners and also for traditional economically dependent children.
4. HBD-12. The attached sample HBD-12 identifies pen-and-ink changes, which should be made to the form to enroll domestic partners and their children.

Tax Implications

The additional benefit of providing health benefits to a domestic partner and children of a domestic partner is a taxable benefit for the enrolled individual. Employees seeking to enroll domestic partners must be made aware of these tax implications. Employers should consult their tax counsel regarding withholding requirements for these additional benefits.

Section II. New Affidavit of Eligibility for Economically Dependent Children

We have revised the Affidavit of Eligibility for Economically Dependent Children to incorporate provisions for Domestic Partners, as well as to clarify the process and make the form easier to use.

The most notable change is the deletion of the notary public requirement for the form. Second, we have established basic criteria for the "parent-child relationship" required under law. This area has always been difficult to administer, but the considerations to use in evaluating applications remain the same:

1. Legal documentation granting custody of the child usually is sufficient to establish entitlement for enrollment
2. In the case of children who are not under the court-ordered custody of the member, the member must still assert a financial obligation to the child and demonstrate they are acting in a parent-child relationship with the child.

Historically, CalPERS has held that the presence of the birth-parent in the household would make the establishment of the parent-child relationship with a third party impossible in most cases. However, it is recognized that sometimes, the birth-parent may not be able to fulfill their parental responsibilities (i.e.: profound physical or mental disability; minor age of the birth-parent; so forth).

3. In the case of a domestic partner's child, the legal requirements for establishing a domestic partnership require a sharing of financial obligations. The existence of the registered domestic partnership is sufficient to demonstrate the financial obligation of the member.

The law also requires the sharing of a common residence, therefore, the presence of the birth-parent in the household is expected and does not adversely impact the member's ability to establish a parent-child relationship.

As always, CalPERS is ready to assist you in administering this provision.

Section III. Health Vesting Requirements For Future Retirees

Currently, agencies participating in the CalPERS Health Benefits Program are required to provide a retiree health contribution regardless of the number of years of credited service a retiree had with the agency. Recent legislation amended Sections 22825.5 and 22859.2 of the Government Code to provide all public agencies and school employers the option of contracting for a health benefit vesting requirement for future retirees. The vesting is based on an employees credited years of service.

Public Agencies and School Employers

Effective January 1, 1999, AB 2764, Chapter 996, allows all participating public agencies and school employers the opportunity to implement a post retirement health vesting schedule for future retirees. Employers electing the contribution method under section 22825.5 must provide a contribution to all **employees and annuitants**. The contribution is based upon the State's 100/90 formula (Government Code Section 22825.1).

The employer's contribution for post retirement health would be based on an employee's years of CalPERS credited service as defined in Section 20069 of the Government Code. An employee must have a minimum of 10 years of credited service, five of which must be with your agency before a health contribution would be payable by your agency.

Credited service for agencies with their own retirement system must include all service with your agency and any CalPERS credited service. An employee must have a minimum of 10 years of credited service, five of which must be with your agency before a health contribution would be payable by your agency.

The percentage of employer contribution payable for post retirement health would be the same as the vesting schedule used by the State of California (Government Code Section 22825.3). The contributions vary year to year based on the State's 100/90 formula (Government Code 22825.1). Currently the State's 1999 retiree contribution is \$180.00 for one party, \$333.00 for two party and \$411.00 for family. The 2000 retiree contribution is \$181.00 for one party, \$344.00 for two party and \$441.00 for family.

The vesting requirements will only apply to employees who retire for service and who are first employed during the time period specified in the Memorandum of Understanding (MOU). The specified time period begins on the effective date of the resolution and ends on the date specified in the MOU. In the case of employees not represented by a bargaining unit, the employer files a certification with CalPERS that there is not an applicable MOU. Vesting requirements will not apply to disability retirements.

School Employers. Only

Effective January 1, 1999, AB 2764, Chapter 996, allows all participating School Employers the opportunity to implement a post retirement health vesting schedule for future retirees. Under Section 22859.2, the employer contribution will be based on negotiations through the collective bargaining process for represented employees and by employer decision for non-represented employees. Once negotiated, the employers' contribution for post retirement health will be based on the employee's years of service credit with the school employer. Five years of credited service must be worked with a school employer before an employer contribution for retirees is required.

The vesting requirements will not apply to retirees who retired prior to the effective date of the MOU. Employees who retire after the effective date of the MOU will receive the same employer contribution within their recognized employee group. Vesting requirements will not apply to disability retirements.

To implement the vesting requirements, the following information is needed:

Public Agencies and School Employers

- A resolution electing to be subject to Government Code Section 22825.5. The effective date will be the first day of the second month following the month the resolution is received in the CalPERS office.
- Identify employees **first hired** on or after the time period specified in the MOU or certification effective date. Once retired, these employees will be subject to the vesting requirements.

School Employers, Only

- A resolution electing to be subject to Government Code Section 22859.2. The effective date of the change in contribution will be the first of second month received in the CalPERS office.
- Identify employees **first hired** on or after the time period specified in the MOU or certification effective date. Once retired, these employees will be subject to the vesting requirements.

Inquiries regarding Public Agency and School Employer vesting should be directed to:

Carol Abbott	(916) 326-3596
Rosie Jimenez	(916) 326-3364
Janice Matsumoto	(916) 326-3593
Terri McIntyre	(916) 326-3587
Bruce Sakai	(916) 326-3599

Should you have any questions regarding these issues, please contact our Customer Service staff at the number above.


FRED STEINMETZ, Chief
Health Benefit Services Division

Enclosures:

Statement of Financial Liability for Domestic Partner
New Affidavit of Economically-Dependent Children
HBD-12, Health Benefit Plan Enrollment Form Instructions and Samples



Health Benefit Services Division
P.O. Box 942714
Sacramento, CA 94229-2714

Toll Free: (800) 237-3345 Local: (916) 326-3970
TDD: (916) 326-3240 Fax: (916) 658-1313

Statement of Financial Liability For Domestic Partner Health Benefits

I, _____ agree that I may be required to
(Full Name of Subscribing Individual)
reimburse my employer, my designated health benefits plan, and the California Public Employees' Retirement System, for any expenditures made by my employer, my designated health benefits plan, and the California Public Employees' Retirement System, for medical claims, processing fees, administrative charges, costs, and attorney's fees incurred in conjunction with providing health coverage under the Public Employee's Medical and Hospital Care Act to my domestic partner or any of his or her dependents if any of the submitted documentation is found to be incomplete, inaccurate, or fraudulent.

Full Name of Subscriber _____

Signature _____

Full Name of Domestic Partner _____



AFFIDAVIT OF ELIGIBILITY FOR ECONOMICALLY DEPENDENT CHILDREN

The Public Employees' Medical and Hospital Care Act (PEMHCA) and regulations allow for the enrollment of a child (other than natural, adopted, or step-child) in a CalPERS-sponsored health plan when the employee or annuitant has a "parent-child relationship" with the child and the child is economically dependent on the employee or annuitant. The child must never have been married and must be under the age of 23 (except for certain disabled dependents). Generally, the parent-child relationship exists when either,:

- The employee or annuitant has legal custody or joint legal custody of the child; or
- The child resides with the employee or annuitant (generally in the absence of the natural or adoptive parent), and is economically dependent upon the employee or annuitant; or
- The child is the natural, adopted, step or economically dependent child of the employee or annuitant's Domestic Partner.

Employee/Annuitant Information:

Name	Social Security Number
Date Acquired Dependent: / /	

Dependent Information:

Name	Social Security Number
Date of Birth / /	Relationship to Employee/Annuitant

Certify by checking the appropriate box:

- ☐ I have been granted legal custody or joint legal custody of the dependent named above. A copy of the Court Order is attached.
- ☐ I have a parent-child relationship with the dependent named above, who resides with me and is economically dependent upon me and whose natural or adoptive parent:
- ☐ Does not live in my household
 - ☐ Lives in my household, but cannot fulfill parental responsibilities.
- ☐ I have established financial responsibility for the dependent named above through my domestic partnership. I have assumed the parent-child relationship along with my domestic partner.

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying my Personnel Office or CalPERS immediately if there are any changes pertaining to this child's status as my dependent. I agree to provide supporting documentation, such as, but not limited to, court records, birth certificate, proof of school registration, tax returns, statement of financial liability, or any other documents, when requested by my employer (or CalPERS) as long as the child is enrolled as my dependent. I understand that if I request to enroll additional miscellaneous children, certification of all existing miscellaneous children is required. I hereby certify, under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge.

Employee/Annuitant Signature

Date

Employer's Signature

Date Received In Employing Office

HBD-12 Modifications for Domestic Partner Enrollment

The HBD-12 will be used to establish enrollment for domestic partners in the CalPERS Health Benefit Program.

Health Benefit Officers shall obtain Domestic Partner Social Security Numbers and report them on the HBD-12. HBOs shall make pen and ink modifications to the form in the following manner:

Section 3. Strike through "Spouse" and enter "DP"

Section 7. Check "No" and enter "DP" to the right of the "No" box.

Sections 17 and 18. In the "Family Relationship" box, enter "DP" for Domestic Partner and "DPC" for children of domestic partners.

Section 35. "Remarks"—Annotate this area to indicate:

"Domestic Partnership Registration and Statement of Financial Liability on file".

If additional children are added, indicate:, "Affidavits of Economically-Dependent Children on file."



Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN
ENROLLMENT FORM
PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input checked="" type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER 111 — 22 — 3333	ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH	Family Relationship	CODE
17. BASIC PLAN	Mo. Day Yr.		SELF			
3. SOCIAL SECURITY NUMBER 789 — 12 — 3456 DP	(FIRST) (MI) (LAST) Jane A. Doe			02 02 65		
4A. Name Jane A. Doe	(FIRST) (MI) (LAST) 1515 Any Street	A	Shirley M. Riverside	10 10 64	DPF	B
Mailing Address City, State, ZIP Anytown, CA 95523		A	Donald Riverside	01 01 88	DPCM	C
		A	Sallyjo Riverside	08 03 90	DPCF	D
4B. RESIDENCE ZIP CODE (if different from 4A)						
5. Please check if Permanent Intermittent Employee (applies to active State employees only)	6. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	7. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No DP				
8. PLAN CODE 2223	9. NAME OF HEALTH PLAN PERS Choice					
10. GROSS PREMIUM \$ 458.00	11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP					
12. PRIOR PLAN CODE 2221	13. PRIOR HEALTH PLAN PERS Choice					
14. Permitting Event Code	15. Permitting Event Date Mo. Day Year 01 01 00	16. EFFECTIVE DATE Mo. Day Year 02 01 00	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo. Day Yr.	Relation-ship	CODE

19. CHECK ONE

- ☐ I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☒ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse)

(Current Signature Required)

21. DATE SIGNED
Mo. Day Year
01 10 00

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One) 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input checked="" type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION CalPERS	27. BARGAINING UNIT 4
28. AGENCY NAME (or Retirement System) City of Buena Vista	29. PAYROLL OFFICE CODE 5	30. AGENCY CODE 1111	31. UNIT CODE		

32. I hereby certify under penalty of perjury as follows:

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in
employing office
Mo. Day Yr.
01 15 00

34. PHONE NUMBER

(555) 333-4444

I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

HBO Signature

35. REMARKS Domestic Partnership Registration, Statement of Financial Responsibility
of Forms and Affidavit of Economically
Dependent Children on File



Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN
ENROLLMENT FORM

PERS—HBD-12 (Rev. 10/93)

**DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS**

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input checked="" type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage		2. SOCIAL SECURITY NUMBER 012 — 34 — 5678		ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:			DATE OF BIRTH			Family Relationship	C CODE		
3. SOCIAL SECURITY NUMBER 111 — 22 — 3333 DP		17. BASIC PLAN (FIRST) (MI) (LAST) John A. Doe			Mo.	Day	Yr.	SELF						
4A. Name John A. Doe		4B. RESIDENCE ZIP CODE (If different from 4A)		ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)			DATE OF BIRTH			Relationship	C CODE		
Mailing Address 1234 Main Street City, State, ZIP Anytown, CA 95123														
5. Please check if Permanent Intermittent Employee (applies to active State employees only)		6. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		7. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No DP										
8. PLAN CODE 2221		9. NAME OF HEALTH PLAN PERS Choice												
10. GROSS PREMIUM \$ 296.00		11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP												
12. PRIOR PLAN CODE 2223		13. PRIOR HEALTH PLAN PERS Choice												
14. Permitting Event Code		15. Permitting Event Date Mo. Day Year 10 02 00		16. EFFECTIVE DATE Mo. Day Year 11 01 00										
19. CHECK ONE <input type="checkbox"/> I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act. <input checked="" type="checkbox"/> I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act. <input type="checkbox"/> I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.														

19. CHECK ONE

- ☐ I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☒ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse) (Current Signature Required)	21. DATE SIGNED Mo. Day Year 10 30 00
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PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One) 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input checked="" type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION CaPERS	27. BARGAINING UNIT 4
28. AGENCY NAME (or Retirement System) California Public Agency			29. PAYROLL OFFICE CODE 5	30. AGENCY CODE 1111	31. UNIT CODE

32. I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.	SIGNATURE OF HEALTH BENEFITS OFFICER (HBO Signature)	33. Date received in employing office Mo. Day Yr. 10 30 00	34. PHONE NUMBER (555) 678-1234
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35. REMARKS

_____ of _____ Forms